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LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Correspondents are asked to be brief

Care of the Dying

SIR,—I was most interested to read your leading article (6 January, p. 5) and the shortened versions of the papers that you printed of the Department of Health and Social Security symposium on the "Care of the Dying" (6 January, p. 29).

Your leading article and one of the speakers suggested that 12 beds for every half-million people might be required in specialist terminal-care units. However, a small survey carried out in Manchester[1] in 1969 suggested that approximately half those patients who died from malignant disease at home might have accepted support and care from alternative facilities, while approximately half those patients who died in hospital had been admitted for nursing care and not the continuation of acute treatment. In this population of just over 600,000 it was suggested that approximately 70 patients dying from malignant disease in one month might have been referred to special facilities, had these been available. An average period of nursing of one month per patient would thus require 70 places. A study carried out in Reading[2] in 1969 and 1970 suggested that for a population of 400,000 approximately 20 places were required for all cancer patients requiring terminal care.

There is, of course, no consensus about the provision of such accommodation, and relatively few population-based studies have been done to determine the potential requirements. Both the studies mentioned above suggest that the figures quoted at the symposium may be an underestimate of the requirement for this type of care. They contrast with the much lower estimate based on the study by Wilkes,[3] who did not include hospital deaths in his sample and allowed for a much shorter period of terminal nursing. This discrepancy is an indication for further detailed studies of this issue. —I am, etc.,

M. R. ALDERSON

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1 Alderson, M. R., *British Journal of Preventive and Social Medicine*, 1970, **24**, 120.
2 Curnow, R. N., and MacFarlane, S. B. J., unpublished report, Operational Research (Health Services) Unit, Department of Applied Statistics, University of Reading, 1971.
3 Wilkes, E., *Lancet*, 1965, 1, 799.

Radioimmunoassay Follow-up of Hydatidiform Mole

SIR,—Your leading article and Dr. J. W. Crawford's paper (23 December, p. 685 and p. 715) draw attention to a fortunately rare but serious manifestation of trophoblastic disease. The prospective screening programme supported by the Department of Health and Social Security and the Royal College of Obstetricians and Gynaecologists is an exciting development.

Because trophoblastic disease is uncommon there is a greater danger that its clinical handling may not always be in accordance with established practice. To detect choriocarcinoma in its earliest stages and treat it effectively is now possible, and the screening programme advised should prevent some unnecessary suffering. To prevent choriocarcinoma from occurring is better than to diagnose and treat it early. Professor Tow in Singapore,[1] where trophoblastic disease is much more common than it is in Europe, observed that the incidence of carcinoma following hydatidiform mole increased with the age of the patient. For this reason total hysterectomy was practised as the primary treatment of hydatidiform mole in selected cases. The result was a dramatic reduction in the incidence of choriocarcinoma in hospitals such as Kandang Kerbau in Singapore. Having accepted the validity of this work, I believe that in the first case reported by Dr. Crawford primary hysterectomy would have been a safer procedure than hysterotomy and sterilization for a 34-year-old parous woman. The prospective radioimmunoassay programme would make it possible to study in parallel two groups of patients—younger women with reproductive capacity retained and older patients following primary hysterectomy.—I am, etc.,

JOHN STALLWORTHY

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1 Tow, W. S. H., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1966, **73**, 544.

Giddiness

SIR,—Your leading article (30 December, p. 743) on the complex subject of "Giddiness," while excellent in intent and, in places, in execution, perpetuates some dubious and even harmful misconceptions.

Firstly, it is *vertigo* due to vestibular damage that is self-limiting. The patient with "vestibular neuronitis" may have permanent unilateral loss of vestibular function